. No. 2
-11-10-39
5-17-39
I X21492

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 2377

FILED FEB 13 1940

Registration District No. _____ Primary Registration District No. 2001 Registrar's No. 39A

1. PLACE OF DEATH:

(a) County GREEN

(b) City or town SPRINGFIELD
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 724 E. Locust
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)

In this community ____

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County GREEN

(c) City or town SPRINGFIELD, MO
(If outside city or town limits write "RURAL")

(d) Street No. 724 E LOCUST
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME WINN COMBS 512

3. (b) If veteran, name war ____

3. (c) Social Security No. ____

4. Sex MALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife IDA COMBS

6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased FEB (Month) 4 (Day) 1853 (Year)

8. AGE: Years 86 Months 11 Days 8 If less than one day ____ hr. ____ min.

9. Birthplace Ohio (City, town, or county) ____ (State or foreign country)

10. Usual occupation TEACHER

11. Industry or business ____

MOTHER FATHER

12. Name WESLEY COMBS

13. Birthplace DEL (City, town, or county) ____ (State or foreign country)

14. Maiden name MARY OLNEY

15. Birthplace Ohio (City, town, or county) ____ (State or foreign country)

16. (a) Informant Naomie Giles

(b) Address Springfield, Mo.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Jan 17 40 (Month) (Day) (Year)

(c) Place: burial or cremation ROSE HILL CEM

18. (a) Signature of funeral director A. J. Wallace

(b) Address Billings, Mo 290

19. (a) 1/17/40 (Date received local registrar) (b) Chas. A. George M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day FRIDAY 12 year 19 hour 9 minute 30 A.M.

21. I hereby certify that I attended the deceased from 1-11-4, 19__, to 1-12-40, 19__; that I last saw him alive on 1-12-40, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bronchial Pneumonia	2 days
Senility	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ____
Of autopsy ____

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) ____

(b) Date of occurrence ____

(c) Where did injury occur? ____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? ____

While at work? ____ (Specify type of place) (e) Means of injury ____

23. Signature C. L. Simpson M.D. (M. D. or other)

Address Springfield, Mo Date signed 1-13-40

(Licensed Embalmer's Statement on Reverse Side)

Wed 17, 2 o'clock Dr Simpson

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by Everett R. Head, Registered Apprentice No. ..... working under my personal supervision.

Signed Everett R. Head

Licensed Embalmer No. 4038

P. O. Address Billings, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.